Baptist **Memphis Lung Physicians Foundation**

7 pgs (including top page)

Address: 6025 Walnut Grove Rd, Suite 508
City, State, and Zip Code: Memphis, TN 38120

Facsimile Cover Sheet

Date: 4/29/2015 # of pages including cover sheet: 2

Fax

To: Rhonda Barnes

From: Amber / Dr. Wilons

Phone: 662-685-4386 ext 5002

Phone: 901-767-5864

Fax Phone #: 662-685-4341

Fax Phone #: 901-767-6591

Copy:

E-mail:

Remarks: X Urgent ☐ For your review ☐ As requested ☐ Reply ASAP ☐ Please Comment

Re: James Benny Jackson

* Please complete & fax back - You only need to fax back the pages you complete. I just have to send you all of these.

Rhonda
Rhonda Barnes

Please check the one box below that describes what you did with the document(s) you received.

- ☐ The document(s) was shredded. No copies were made or kept.
- ☐ The document(s) was not shredded, but was destroyed so that it would be impossible for someone to piece the document back together. No copies were made or kept.
- ☐ The original document(s) was returned to Baptist at the above address. No copies were made or kept.
- ☐ The document is still in my possession.

Please write in how many pages of documents you unintentionally received from Baptist (count fax cover pages too). However, if you received some documents that were intended for you along with documents that were not intended for you, only count those pages which were not intended for you:_____

Please list the fax number on which the documents were received:_____

Name of person completing this information:_____ **Date:**_____

Form 0100.22 (06/14)

EXHIBIT 1 JACKSON

PENGAD 800-631-6989

Exhibit "13"

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 5/31/2015

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: Blue Mountain Production Company

Employee's job title: Lab Technician / Packaging Operator Regular work schedule: 40 hours weekly

Employee's essential job functions: Attached

Check if job description is attached: ✓

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name:	James	Benny	Jackson
	First	Middle	Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: Mike Wilson 6025 Walnut Grove Memphis, TN 38120

Type of practice / Medical specialty: Pulmonary

Telephone: (901) 767-5864 Fax: 767, 6591

PART A: MEDICAL FACTS

1. Approximate date condition commenced: SYMPTOMS STARTED IN DEC 2014 4/27/15 - 1st Seen in Office

Probable duration of condition: _____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
✓ No ___ Yes. If so, dates of admission:

Date(s) you treated the patient for condition:
4/27/15

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No ✓ Yes.

Was medication, other than over-the-counter medication, prescribed? ___ No ✓ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
✓ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ✓ No ___ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ___ No ✓ Yes.

If so, identify the job functions the employee is unable to perform:
Has had Chronic Congestion, cough without infection needs to be out of Dusty Environment to get control

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

He needed to be removed from his work environment to avoid exposure to dust. His persistent bronchospasm is most likely related to the dust in his work environment. Plan to maximize his bronchodilators to see if we can get his bronchospasm to completely resolve. He will have follow-up in one month with CXR & PFTS.

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? __No ✓ Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: unknown

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? __No __Yes (Yes) needs to DOI permanent

   If so, are the treatments or the reduced number of hours of work medically necessary?
   __No __Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
   I will see back during 1st month to determine

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? __No ✓ Yes. Very possibly

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   __ No __ Yes. If so, explain:

   Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ___ times per ___ week(s) ___ month(s) To be Determined

Duration: ___ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

He has persistent bronchospasm (wheeze) which is his cough
[illegible] x 4 [illegible]
Needs to be out of dusty environment while [illegible] to [illegible] gain control of wheeze,

 CONTINUED ON NEXT PAGE

Michael Wilson 5/8/15

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 4/30/2015

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: James Benny Jackson
Employee

FROM: Rhonda Barnes
Employer Representative

DATE: 05/05/2015

On 04/27/2015, you informed us that you needed leave beginning on 4/27/2015 for:

____ The birth of a child, or placement of a child with you for adoption or foster care;

✓ Your own serious health condition;

____ Because you are needed to care for your ____ spouse; _____child; _____ parent due to his/her serious health condition.

____ Because of a qualifying exigency arising out of the fact that your ____ spouse; _____son or daughter; _____ parent is on covered active duty or call to covered active duty status with the Armed Forces.

____ Because you are the ____ spouse; _____son or daughter; _____ parent; _____ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

✓ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

____ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

____ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.

____ You have not met the FMLA's hours of service requirement.

____ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact Rhonda Barnes (662) 685-4386, ext 5002 or view the FMLA poster located in Office Breakroom.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** _____. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

✓ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ✓ is/____ **is not** enclosed.

____ Sufficient documentation to establish the required relationship between you and your family member.

____ Other information needed (such as documentation for military family leave): _____

_____

_____

____ No additional information requested

CONTINUED ON NEXT PAGE

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

____ Contact _____ at _____ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.

✓ You will be required to use your available paid _____ **sick,** ✓ **vacation,** and/or _____ **other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.

____ Due to your status within the company, you are considered a "key employee" as defined in the FMLA. As a "key employee," restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We ___**have**/____ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.

✓ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every Visit _____. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:

  _____ the calendar year (January – December).

  _____ a fixed leave year based on _____.

  _____ the 12-month period measured forward from the date of your first FMLA leave usage.

  ✓ a "rolling" 12-month period measured backward from the date of any FMLA leave usage.

- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on _____.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have ____ **sick,** ____**vacation,** and/or ___ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

  ____For a copy of conditions applicable to sick/vacation/other leave usage please refer to _____ available at: _____.

  ____Applicable conditions for use of paid leave:_____

Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:

Rhonda Barnes at 662-685-4386, ext. 5002.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**